		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040865

Facility Name: DIXON HEALTH CARE CENTER

Address: 111 NORTH COURT (Number) DIXON (City) 61021 (Zip Code)

County: LEE

Telephone Number: (815) 288-1477 **Fax #** (815) 288-9512

IDPA ID Number: 75-2080781

Date of Initial License for Current Owners: 09/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713, Ext 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) LINDA HOLTZSCHEITER
(Title) REIMBURSEMENT MANAGER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting
(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation, 16162 Beach Blvd, #308, Huntington Beach, CA 92647
(Telephone) (714) 596-7713 Fax # (714) 596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,741	655	1,486	5,882	8
9	SNF/PED					9
10	ICF	14,907	7,096		22,003	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,648	7,751	1,486	27,885	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.45%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,471

Medicare Intermediary AdminaStar Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	127,220	9,518	6,273	143,011		143,011	(4,069)	138,942			1
2	Food Purchase		132,217		132,217		132,217		132,217			2
3	Housekeeping	63,334	13,408		76,742		76,742		76,742			3
4	Laundry	40,690	7,667		48,357		48,357		48,357			4
5	Heat and Other Utilities			79,783	79,783		79,783	437	80,220			5
6	Maintenance	56,089	27,857	37,472	121,418		121,418	363	121,781			6
7	Other (specify):*											7
8	**TOTAL General Services**	287,333	190,667	123,528	601,528		601,528	(3,269)	598,259			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,056,405	43,649	200,861	1,300,915		1,300,915		1,300,915			10
10a	Therapy	14,164	117	56,541	70,822		70,822		70,822			10a
11	Activities	98,472	3,654	1,593	103,719		103,719		103,719			11
12	Social Services	35,157	25	1,442	36,624		36,624		36,624			12
13	Nurse Aide Training	14,792		700	15,492		15,492		15,492			13
14	Program Transportation	18,627		1,603	20,230		20,230		20,230			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,237,617	47,445	268,740	1,553,802		1,553,802		1,553,802			16
	C. General Administration											
17	Administrative	63,014			63,014		63,014		63,014			17
18	Directors Fees											18
19	Professional Services			3,159	3,159		3,159	3,563	6,722			19
20	Dues, Fees, Subscriptions & Promotions			6,288	6,288		6,288	105	6,393			20
21	Clerical & General Office Expenses	76,652	6,303	170,186	253,141		253,141	(79,009)	174,132			21
22	Employee Benefits & Payroll Taxes			300,207	300,207		300,207		300,207			22
23	Inservice Training & Education			3,048	3,048		3,048		3,048			23
24	Travel and Seminar			8,764	8,764		8,764	2,741	11,505			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,816	91,816		91,816	(51,141)	40,675			26
27	Other (specify):*											27
28	**TOTAL General Administration**	139,666	6,303	583,468	729,437		729,437	(123,741)	605,696			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,664,616	244,415	975,736	2,884,767		2,884,767	(127,010)	2,757,757			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DIXON HEALTH CARE CENTER #0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,288	8,288		8,288	74,023	82,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			51,031	51,031		51,031		51,031			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,086	11,086		11,086		11,086			35
36	Other (specify):* see 4.2 attchd							4,085	4,085			36
37	**TOTAL Ownership**			70,405	70,405		70,405	78,108	148,513			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,264	11,428	35,692		35,692		35,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		24,264	71,653	95,917		95,917		95,917			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,664,616	268,679	1,117,794	3,051,089		3,051,089	(48,902)	3,002,187			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,069)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,371)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,929)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,369)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,467		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,467		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (48,902)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

DIXON HEALTH CARE CENTER

ID# 0040865

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Tax	$ (1,454)	21	1
2	Memorium/Benevolence Expense	(463)	21	2
3	Misc Receipts	(11,880)	21	3
4	Personal Purchases - Vending	(973)	21	4
5	Depreciation Reconciliation	29,584	30	5
6	FAS 121*	44,439	30	6
7				7
8	Marketing Director Wages	(31,647)	21	8
9	Professional Liability Insurance	(51,535)	26	9
10				10
11				11
12				12
13				13
14				14
15				15
16	* The provider re-valued the historical cost of its			16
17	assets. This adjustment is required to report			17
18	the historical cost of the assets in consistency			18
19	with prior years.			19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,929)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,069)	0	0	0	0	0	0	0	0	0	0	(4,069)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	437	0	0	0	0	0	0	0	0	0	437	5
6	Maintenance	0	363	0	0	0	0	0	0	0	0	0	363	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,069)	800	0	0	0	0	0	0	0	0	0	(3,269)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,563	0	0	0	0	0	0	0	0	0	3,563	19
20	Fees, Subscriptions & Promotions	0	105	0	0	0	0	0	0	0	0	0	105	20
21	Clerical & General Office Expenses	(146,788)	67,779	0	0	0	0	0	0	0	0	0	(79,009)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,741	0	0	0	0	0	0	0	0	0	2,741	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(51,535)	394	0	0	0	0	0	0	0	0	0	(51,141)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(198,323)	74,582	0	0	0	0	0	0	0	0	0	(123,741)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(202,392)	75,382	0	0	0	0	0	0	0	0	0	(127,010)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **DIXON HEALTH CARE CENTER** **#** **0040865** **Report Period Beginning:** **1/1/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	74,023	0	0	0	0	0	0	0	0	0	0	74,023	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	4,085	0	0	0	0	0	0	0	0	0	4,085	36
37	**TOTAL Ownership**	74,023	4,085	0	0	0	0	0	0	0	0	0	78,108	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,369)	79,467	0	0	0	0	0	0	0	0	0	(48,902)	45

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network	100.00%	$ 437	$ 437	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	363	363	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	3,563	3,563	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	105	105	4
5	V	10	Nursing and Medical Records		Mariner Post Acute Network	100.00%			5
6	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	67,779	67,779	6
7	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	2,741	2,741	7
8	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	394	394	8
9	V	36	Depreciation		Mariner Post Acute Network	100.00%			9
10	V	36	Taxes-Property		Mariner Post Acute Network	100.00%	16	16	10
11	V	36	Rental & Leasing		Mariner Post Acute Network	100.00%	725	725	11
12	V	36	Lease Expense		Mariner Post Acute Network	100.00%	3,344	3,344	12
13	V	36	Property Insurance		Mariner Post Acute Network	100.00%			13
14	Total			$			$ 79,467	$ * 79,467	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravine Dr., Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			$ 20,767	$		$ 437	1
2	6	Repairs and Maintenance	Facility Costs			9,731			363	2
3	19	Professional Services	Facility Costs			205,127			3,563	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			6,427			105	4
5	10	Nursing and Medical Records	Facility Costs			67,554				5
6	21	Clerical and General Office Exp	Facility Costs			6,582,242			67,779	6
7	24	Travel and Seminar	Facility Costs			638,416			2,741	7
8	26	Insurance Premium	Facility Costs			(129,286)			394	8
9	36	Depreciation	Facility Costs			735,846				9
10	36	Taxes-Property	Facility Costs			30,882			16	10
11	36	Rental & Leasing	Facility Costs			185,889			725	11
12	36	Lease Expense	Facility Costs			98,311			3,344	12
13	36	Property Insurance	Facility Costs			76				13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,451,982	$		$ 79,467	25

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	28,429	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	48,601	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,172	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,859	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	51,031	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	42,404	8
1997	46,169	9
1998	47,121	10
1999	44,583	11
2000	49,828	12

2001 REAL ESTATE ACCRUAL: $30,982

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DIXON HEALTH CARE CENTER COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0040865

CONTACT PERSON REGARDING THIS REPORT Cathy Simeoni

TELEPHONE (714) 596-7713, Ext 12 FAX #: (714) 596-7721

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-02-32-126-005	00000141 North Ct, assrs plt 2 nh, pt lt	$ 49,827.72	$ 49,827.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,827.72	$ 49,827.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,710 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		1993	1976	$ 1,100,000	$ 31,429	35	$ 31,429	$	$ 258,132	4
5			1993		185,306	9,266	20	9,266		114,484	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	PARKING LOT REPAIRS			1996	2,925	146	20	146		774	10
11	ARCHITECT-TRANSICARE UNIT			1996	548	27	20	27		156	11
12	DOOR AND FRAME			1996	2,215	111	20	111		590	12
13	TILE FLOORING			1996	7,000	350	20	350		1,822	13
14	PAINTING			1996	3,115	156	20	156		803	14
15	DOORS AND FRAME			1996	2,215	111	20	111		568	15
16	INSTALL CEILING			1997	6,905	345	20	345		1,765	16
17	LAUNDRY REPAIR			1996	3,314	166	20	166		906	17
18	FLOOR CERAMIC TILE			1997	5,334	267	20	267		1,334	18
19	PAINT BUILDING			1997	3,021	151	20	151		690	19
20	CARPET			1997	1,439	72	20	72		330	20
21	GUTTERS & WINDOWS			1997	2,932	147	20	147		636	21
22	WALLS AND FLOORING			1997	1,100	55	20	55		226	22
23	STOREFRONT CONSTRUCTION			1998	8,353	209	20	209		836	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CONCRETE FOUNDATION	1998	$ 720	$ 36	20	$ 36	$	$ 144	37
38	ROOF COVERING/GUTTERS	1998	16,491	412	20	412		1,648	38
39	DUMPSTER AREA	1998	500	25	20	25		100	39
40	HVAC	1998	8,395	420	20	420		1,680	40
41	SECURITY SYSTEM	1998	2,284	114	20	114		456	41
42	CURTAINS & DRAPES	1998	1,985	99	20	99		396	42
43	AT&T PHONE SYSTEM	1993	6,676	668	20	334	(334)	4,024	43
44	HVAC UNITS	1994	1,787	179	20	89	(90)	990	44
45	HVAC UNITS	1994	2,680	268	20	134	(134)	1,487	45
46	HVAC COMPRESSOR	1994	2,747	275	20	137	(138)	1,424	46
47	A/C (5)	1995	4,964	496	20	248	(248)	2,216	47
48	A/C UNITS	1996	4,144	414	20	208	(206)	1,510	48
49	A/C (12)	1996	11,644	1,164	20	582	(582)	4,095	49
50	A/C UNIT	1996	1,057	106	20	53	(53)	356	50
51	A/C FAN MOTORS	1996	583	58	20	29	(29)	191	51
52	A/C - HEATING	1996	1,145	115	20	57	(58)	364	52
53	BASE HEATERS	1996	1,908	191	20	95	(96)	606	53
54	CURTAINS & DRAPES	1996	2,800	280	20	140	(140)	860	54
55	WATER STORAGE TANK	1996	1,114	111	20	56	(55)	326	55
56	CURTAINS & DRAPES	1997	10,592	1,059	20	530	(529)	3,057	56
57	DRAPE INSTALLATION	1997	820	82	20	41	(41)	214	57
58	ELEVATOR REPAIRS	1997	6,780	678	20	339	(339)	1,833	58
59	HOT WATER BOOSTER	1997	851	85	20	43	(42)	224	59
60	CUBICLE CURTAINS	1997	6,857	686	20	343	(343)	1,718	60
61	A/C UNITS (6)	1997	6,251	625	20	313	(312)	1,519	61
62	SECURITY SYSTEM	1997	2,284	228	20	114	(114)	478	62
63	CUBICLE CURTAINS	1997	4,952	495	20	248	(247)	1,073	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,448,733	$ 52,377		$ 48,247	$ (4,130)	$ 417,041	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,448,733	$ 52,377		$ 48,247	$ (4,130)	$ 417,041	1
2	RECONCILING ADJUSTMENT TO WTB 1998	1998		14,956			(14,956)		2
3	LANDSCAPING	1998	1,198	30	20	30		120	3
4									4
5	4: RA/C QUIET ZONE 660	1999	1,280	256	5	256		640	5
6	ELECTRICAL WORK	1999	180	9	20	9		22	6
7	PLUMBING - WATER HEATER	1999	666	67	10	67		161	7
8	1: LOCHINVAR COPPER -	1999	4,366	437	10	437		1,055	8
9	PARTIAL ELEVATOR DOOR	1999	8,024	401	20	401		1,070	9
10									10
11	NURSE CALL SYSTEM	2000	1,986	199	10	199		414	11
12	INSTALL CHARGE, NURSE CALL SYSTEM	2000	1,415	142	10	142		259	12
13	NURSE CALL, SECOND INSTALL FEE	2000	2,000	200	10	200		317	13
14	2:RETROAIRE CHASSIS, DINING RM	2000	2,458	492	5	492		778	14
15	INSTALL 4" STEEL FIRE LINE	2000	1,132	45	25	45		72	15
16	FIRE ALARM PANEL INSTLD	2000	919	92	10	92		138	16
17	RPLC 4" GAS MAIN, LABOR ONLY	2000	662	26	25	26		42	17
18	RPLC 4" GAS MAIN	2000	802	32	25	32		51	18
19	CORE, GRADE SWAIL, WATER DRAINS	2000	3,405	227	15	227		341	19
20	BLDG GROUNDS REINFORCED, DRAINA	2000	3,900	260	15	260		390	20
21									21
22	RPRS 7,403 SqFt Roof Patches	2001	39,400	985	15	985		985	22
23	7403 SqFt Roof Repairs	2001	39,400	657	15	657		38,743	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,561,926	$ 71,889		$ 52,803	$ (19,086)	$ 462,637	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 288,627	$ 28,824	$ 28,824	$		$ 218,763	71
72	Current Year Purchases	6,520	685	685			685	72
73	Fully Depreciated Assets	45,400					45,400	73
74								74
75	TOTALS	$ 340,547	$ 29,508	$ 29,508	$		$ 264,848	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,902,473	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,397	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,311	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,086)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 727,485	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	OVERHEAD ALLOCATION - 1996	$ 4,649	$ 232	$ 1,191	86
87	OVERHEAD ALLOCATION - 1997	2,976	149	655	87
88					88
89					89
90					90
91	TOTALS	$ 7,625	$ 381	$ 1,846	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,086 Description: Vehicle: $9,946; Non-Medical Equipment $1,140
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Medical Transportation	1999 FORD Econoline Wa	$ 915.00	$ 9,946	17
18					18
19					19
20					20
21	TOTAL		$ 915.00	$ 9,946	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 42.5

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			1,074		1,074
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		7,202		7,202
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			700		700
9	TOTALS		$	$ 8,976	$	$ 8,976
10	SUM OF line 9, col. 1 and 2	(e)	$ 8,976			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	16

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		89 hrs	$ 2,688		$	$	89	$ 2,688	1
2	Licensed Speech and Language Development Therapist		hrs			(101)			(101)	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	624		3,776	117		4,517	4
5	Physician Care		visits							5
6	Dental Care		visits			21			21	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		265	11,385	24,264	265	35,649	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					22			22	13
14	TOTAL			$ 3,312	265	$ 15,103	$ 24,381	354	$ 42,796	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DIXON HEALTH CARE CENTER **#** 0040865 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 580	$	1
2	Cash-Patient Deposits	132,099		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	223,674		3
4	Supply Inventory (priced at)	20,565		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	85,438		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 462,356	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,386		13
14	Buildings, at Historical Cost	222,238		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	92,018		16
17	Accumulated Depreciation (book methods)	(198,530)		17
18	Deferred Charges	54,000		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 271,112	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 733,468	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,497	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,314		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,266)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,859		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE 17.1	1,818,851		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,160,255	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED SCHEDULE 17.1	3,848,505		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,848,505	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,008,760	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,275,291)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 733,469	$	48

***(See instructions.)**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,997,506)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,997,506)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(290,447)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (290,447)	17
	B. Transfers (Itemize):		
18	INTERCOMPANY TRANSFER	12,662	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 12,662	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,275,291)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,279,070	1
2	Discounts and Allowances for all Levels	(722,278)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,556,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,171	6
7	Oxygen	7,986	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 131,157	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,069	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,720	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,959	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59,748	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	973	28
28a	Miscellaneous Receipts	11,972	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,945	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,760,642	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	601,528	31
32	Health Care	1,553,802	32
33	General Administration	729,437	33
	B. Capital Expense		
34	Ownership	70,405	34
	C. Ancillary Expense		
35	Special Cost Centers	35,692	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,051,089	40
41	**Income before Income Taxes (line 30 minus line 40)****	(290,447)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (290,447)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,131	$ 49,644	$ 23.30	1
2	Assistant Director of Nursing	997	1,082	19,642	18.15	2
3	Registered Nurses	19,403	21,045	389,382	18.50	3
4	Licensed Practical Nurses	8,330	9,035	136,277	15.08	4
5	Nurse Aides & Orderlies	44,358	48,110	470,518	9.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	89	97	3,562	36.72	7
8	Rehab/Therapy Aides	309	336	11,334	33.73	8
9	Activity Director	403	437	4,999	11.44	9
10	Activity Assistants	10,248	11,115	92,402	8.31	10
11	Social Service Workers	3,155	3,421	33,578	9.82	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,126	29,236	13.75	13
14	Head Cook	6,009	6,518	53,393	8.19	14
15	Cook Helpers/Assistants	6,399	6,940	44,562	6.42	15
16	Dishwashers					16
17	Maintenance Workers	5,029	5,455	56,409	10.34	17
18	Housekeepers	8,287	8,989	63,973	7.12	18
19	Laundry	5,900	6,399	41,776	6.53	19
20	Administrator	2,032	2,204	56,216	25.51	20
21	Assistant Administrator					21
22	Other Administrative	1,901	2,062	23,936	11.61	22
23	Office Manager					23
24	Clerical	1,752	1,900	20,319	10.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	954	1,035	10,315	9.97	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/Driver	3,966	4,302	53,143	12.35	33
34	TOTAL (lines 1 - 33)	133,446	144,739	$ 1,664,616 *	$ 11.50	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	140	$ 5,402	1-3	35
36	Medical Director	156	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,593	11-3	44
45	Social Service Consultant	36	1,442	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	368	$ 14,437		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	72	$ 2,965	10-3	50
51	Licensed Practical Nurses	1,232	38,873	10-3	51
52	Nurse Aides	7,195	148,754	10-3	52
53	TOTAL (lines 50 - 52)	8,499	$ 190,592		53

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Cain	Administrator	0	$ 63,014
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,014

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LEGAL FEES	SEE ATTACHED SCHED.	$ 3,159
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,159

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,433
Unemployment Compensation Insurance	19,779
FICA Taxes	123,458
Employee Health Insurance	102,035
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,502
TOTAL (agree to Schedule V, line 22, col.8)	$ 300,207

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	5,703
Other License fees	385
Home Office Allocation	105
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,393

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	8,764
Home Office Allocation	2,741
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,505

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTHCARE ASSOCIATION**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,225**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **427**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.